. No. 2
-4-13-40
5-17-39
I X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41127 4808

Registration District No. ____ Primary Registration District No. ____ Registrar's No. ____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
In this community About 56 Yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 048
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3226 Brooklyn
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Fred Brack
3. (b) If veteran, name war No
3. (c) Social Security No. NO

4. Sex Male 0
5. Color or race Wh
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Elizabeth A. Brack
6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased Dec. (Month) 27 (Day) 1882 (Year)

8. AGE: Years 58 Months 11 Days 26 If less than one day ____ hr. ____ min.

9. Birthplace Council Bluffs (City, town, or county) Iowa (State or foreign country) 1
10. Usual occupation Piano Teacher
11. Industry or business

MOTHER
12. Name John Brack
13. Birthplace ____ (City, town, or county) Germany (State or foreign country) 4

FATHER
14. Maiden name Helen Rinefel
15. Birthplace ____ (City, town, or county) Germany (State or foreign country) 4

16. (a) Informant Mrs. Elizabeth A. Brack
(b) Address 3226 Brooklyn
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-41 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director J. M. Wagner
(b) Address Kansas City, Mo.
19. (a) 12-24-41 (Date received local registrar) (b) M M Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 23rd year 1941 hour 4:-- A.M. minute ____ M.
21. I hereby certify that I attended the deceased from 12-22-41, 19__, to 12-23-41, 19__; that I last saw him alive on 12-23-41, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute generalized peritonitis	
Due to: Intestinal obstruction	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: See above	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Drury R. Thorne (M. D. or other) 0
Address Med. Dir. K. C. Gen. Hospital Date signed

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed A. R. Hainsfeld

Licensed Embalmer No. 4159

P. O. Address K. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—2-21-40
I X22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. Primary Registration District No. Registrar's No. 4808

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General Hospital

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Fred Brock

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race

6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Mch 30 1942 (Date received local registrar) (b) M. M. Browne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 23

year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19, to 19;

that I last saw h alive on 19;

and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute generalized peritonitis	
Due to Intestinal Obstruction	
Due to Incarcerated ventral hernia	
Other conditions (Include pregnancy within 3 months of death) 1.2 1 a 2	
Major findings: Of operations	
Of autopsy 122a2	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

S-41127